

GVSU Annual Open Enrollment Frequently Asked Questions

General Questions

What is a 90%/10% cost sharing relationship?

When looking at the total cost to provide medical and dental coverage to faculty, staff and their dependents (projected to be over \$25 million in 2010) the University will pay approximately 90% and faculty and staff will pay approximately 10%. The 90%/10% cost sharing is based on the aggregate medical and dental cost for the year.

Why are the per pay deduction amounts for each plan different?

The differences in per pay period deduction amounts are based on two factors. The first is the coverage level you select (single, dual or family). The second is the level of coverage provided by the plan. For example, the GVSU Enhanced PPO Plan provides for first dollar coverage when using in-network providers that results in a lower out-of-pocket cost than the GVSU Base PPO Plan. The benefit is richer so the cost is greater.

What is the opt-out credit?

If you have medical or dental coverage through another non-GVSU plan, you may choose the No Coverage option, which enables you to opt out of the GVSU medical and dental plans. To be eligible for the opt-out credit you must provide proof of coverage under another plan. If you and your spouse are both employed by GVSU neither one of you are eligible for the opt-out credit.

Faculty and Staff who select the No Coverage option will receive an opt out cash credit added to their paychecks as taxable income. If you become ineligible for other medical coverage during the year because of a status change as defined under the plan document, you may enroll in any medical plan option by contacting Human Resources within 30 days of losing other coverage.

The amount of the opt out credit is an arbitrary amount that is not tied directly to the actual cost of providing medical and dental benefits. The amount of the opt out credit is evaluated on an annual basis and is benchmarked with other state Universities.

What are the major factors contributing to the rising cost of healthcare?

There are several factors that generally affect the cost of healthcare:

1. An aging population — The average age of our group is approximately 47 years old. By 2020, about 16 percent of the general population in the US will be 65 years of age or older.
2. Lifestyle choices — Seven out ten Americans do not exercise regularly. Inactivity is one of the leading causes of many chronic diseases.
3. Prescription drug costs — Many sources say that the increase in prescription drug costs accounts for about 20 percent of the overall increase in healthcare costs.
4. Cost Shifting — When patients don't have health insurance or their health insurance does not pay for all the care they need, the cost of the care is shifted to those patients with health insurance.
5. Medical Technology — Medical technology helps diagnose conditions earlier allowing for better recoveries. But, it has a big price tag.
(Source: Blue Cross Blue Shield)

GVSU Base and Enhanced PPO Plans

What is a preferred provider organization (PPO) plan, and how does it work?

A preferred provider organization (PPO) plan works for you in two ways: through a panel or network of physicians and other service providers (such as hospitals and labs), or through providers you select that are not in the network. Each time you or a covered family member needs care, you choose whether to see an in-network or an out-of-network provider.

Network providers are listed in your plan's provider directory found online at <http://www.cofinity.net/Cofinity/index.aspx> . When you use an in-network provider, also called "going in-network," you generally receive a higher level of benefits. Also, fees from in-network providers tend to be lower, because the providers and the network have negotiated to have the providers accept certain fees for certain services.

With a PPO plan, do I name a primary care physician (PCP)?

Neither of the PPO Plans require you to name a primary care physician (PCP) or coordinate your care through a particular doctor. However, you are free to choose a primary doctor, whether or not that doctor participates in the network.

What are the advantages of obtaining my care from in-network providers?

There are several advantages when you go in-network. Generally:

- You may not need to pay a deductible, or your deductible may be lower than it would be for out-of-network expenses.
- You don't need to submit claim forms and wait to be reimbursed by your plan.
- Your in-network provider obtains any needed preauthorization for you.
- You generally receive a higher level of benefits because participating providers (doctors, hospitals and other health care facilities) have agreed to provide their services at lower fees.

How does the PPO plan work when I go out-of-network?

Generally, you may use any covered health care provider you choose. However, your cost will generally be higher and you have certain added responsibilities. For example:

- Each year, you may be required to pay part of your eligible out-of-network expenses before the PPO plan begins to pay benefits. This amount is called the deductible.
- After you satisfy the deductible, the plan will reimburse you for a percentage of your eligible expenses and you will pay the balance. The percentage you pay is called your coinsurance percentage.
- You must get preauthorization for certain covered expenses such as a hospital stay. If you don't get the required preauthorization, the amount of benefits available will be reduced or the expenses will not be covered at all. This means your cost will be higher.
- You may be required to complete claim forms and file claims with your health care company to receive payment of benefits.
- The plan will not cover any charges above the allowable amount.

When do I need to file a claim form?

You will not need to file a claim form when you see in-network providers.

When you do need to file a claim form, as you will need to do in most cases when you go out-of-network, your doctor may handle your expense in one of two ways. Most doctors require you to pay the bill right away. In this case, get a receipt and file it with a claim form to be reimbursed. If the expense is covered, you will be reimbursed for part of the bill. To file a claim, follow the instructions on the claim form. If you have more than one health insurance plan and have received an Explanation of Benefits (EOB) form from another health care plan, be sure to include a copy with your claim.

Sometimes doctors are willing to wait for payment. In this case, you or your doctor will file the receipt and completed claim form with your health care company. The health care company will pay the doctor for the part of your expense the plan will cover. The doctor will then bill you for the part the plan did not pay.

What happens in an emergency?

In a true emergency, get the care you need as quickly as you can. If you are able, contact member services for your health care company at the number on your ID card, even in an emergency. However, if you are unable to contact member services, proceed with the care you need. If you need to go out-of-network, your plan will cover emergency care at in-network benefit levels as long as you follow the plan rules.

Check to see how your plan defines a true emergency. Examples typically include severe bleeding, chest pain, and unconsciousness. Also check to see how soon after the onset of the emergency you must notify your health care company in order to be covered in-network.

What happens if I need care while I'm traveling?

If it's not an emergency and you need care while traveling, call member services for your health care company at the number on your ID card. Member services can refer you to an in-network provider.

What is a deductible?

A deductible is the part of eligible expenses you must pay before the plan begins to pay a percentage of your eligible expenses.

Are there expenses that don't count toward my deductible?

Yes. Some of your expenses will not count toward your deductible. For example, any penalty you may pay because you failed to preauthorize treatment through your health care company will not count. For out-of-network care, amounts your care provider charges above the plan's allowable amount for a given service also will not count toward your deductible. Any co-payments made also do not apply to your deductible.

What is coinsurance?

After you satisfy the deductible, the plan will reimburse you for a percentage of your eligible expenses and you will pay the balance. The percentage you pay is called your coinsurance percentage.

What is a copayment?

When you stay in-network, you pay only a fixed amount at the time you receive services. That amount is called your copayment.

What is preauthorization?

Preauthorization is the process by which a health care company or preauthorization company reviews the proposed treatment and tells you and your doctor how benefits may be paid. If you receive care out-of-network, you must obtain preauthorization for certain covered expenses such as a hospital stay. Some plans also require preauthorization for certain in-network services. If you don't get the required preauthorization, your cost will be higher because the benefits payable by the plan will be reduced or the expenses will not be covered at all.

What's the amount known as the "allowable amount," the "U&C amount" or the "R&C amount"?

The terms "allowable amount," "U&C amount" or "R&C amount" vary by plan but refer to the same thing. The allowable, usual and customary or reasonable and customary amount, is the amount usually charged for a given service by most providers in your area. This amount is determined by your health care plan. If your doctor charges you more than this amount, you will not only be responsible for your deductible and coinsurance, but also for the entire difference between the U&C amount and the amount your provider charged. This concept only applies to out-of-network care, because in-network providers have agreed to negotiated fees that are by definition allowable amounts.

For example, suppose you receive a service for which the "U&C amount" is \$100 but your doctor charges you \$110. The health care company will multiply the percentage the plan pays for that service by \$100. So even if the service were covered at 100%, you would pay the \$10 difference (\$110 charge minus \$100 U&C).

What are covered services?

Covered services are services covered by the plan. No medical plan covers everything. If you obtain services that are not covered services, you pay the full cost for those services.

What is an out-of-pocket maximum?

An out-of-pocket maximum is the most you would have to pay out of your own pocket for eligible expenses. Not all plans have an out-of-pocket maximum. Check your Benefits Summary for details. With a plan that has an out-of-pocket maximum, once you reach the out-of-pocket maximum for a given year, the plan would pay all eligible expenses for covered services until any lifetime maximum benefit is reached.

Not all expenses count toward an out-of-pocket maximum. Expenses for services that are not covered under the plan, amounts over any allowable amount limit, and penalties for not preauthorizing care when needed would not count toward your out-of-pocket maximum.

What is a lifetime maximum?

A lifetime maximum is the most that will be paid by the plan for covered services for a given plan member. Not all plans apply a lifetime maximum, and some plans have different lifetime maximums for different services or for in-network and out-of-network services. Once you reach the lifetime maximum, you pay all expenses over that amount.

Priority Health HMO and Grand Valley Health Plan HMO

What is a Health Maintenance Organization (HMO) and how does it work?

A Health Maintenance Organization (HMO) provides health care services to enrolled members through a panel of HMO providers. When you enroll in an HMO, you select a participating PCP for each enrolled family member. You may select any participating PCP from your HMO's provider directory. Your PCP coordinates your medical care, either by providing that care or by issuing a referral to another provider. With an HMO plan, you generally pay a fixed amount each time you receive care. Coinsurance typically does not apply with an HMO.

Except in an emergency as defined by the plan, or with previous approval through the plan's authorization procedures, **only services provided by or referred by your PCP will be covered under an HMO.**

What is a primary care physician (PCP)?

With some HMOs, you are asked to select a primary care physician (PCP) to be the personal doctor for each enrolled family member. If you are asked to select a PCP, you may select any participating PCP from your HMO's provider directory.

What are the advantages of an HMO plan?

There are several advantages when you belong to an HMO. Generally:

- You don't need to submit claim forms and wait to be reimbursed by your plan.
- Your HMO provider obtains any needed precertification for you.
- In most cases, you only pay a copayment (fixed dollar amount) at the time you receive covered services. After you pay your copayment, you owe no more payments for the covered services.

How does an HMO work when I obtain care outside the HMO?

Generally, HMO plans do not cover services provided outside the HMO except in emergency situations.

My plan requires me to select a PCP when I enroll. How do I do so?

When you enroll, you may select any PCP (primary care physician) from your HMO's network provider directory, found online at www.priority-health.com, for each covered family member. Your enrollment materials will request your PCP's name, or a code for that PCP from the network provider directory. You will generally find PCPs in the areas of family practice, general practice, internal medicine, or pediatrics. Some plans allow a woman to name one PCP for her primary care and a second specialist in Obstetrics and Gynecology for services such as pelvic exams and Pap smears.

It's a good idea to check with your HMO before you select a PCP. Some PCPs have "full" practices and cannot accept new patients, and others may no longer be participating in the network.

Can I change my PCP?

Yes. You or a covered family member may change PCPs for any reason. Just call the member services number on your ID card.

Do I ever need to file a claim form with an HMO?

You generally don't need to file a claim form when you see your PCP. Just show your ID card when you receive services so the office knows to charge you a copayment and bill your HMO plan for the balance. The plan works the same way when your PCP refers you to another HMO doctor or hospital for care. Just show your ID card and pay your copayment.

In a true emergency, your eligible expenses may be covered even if you had to go outside the HMO as long as you follow the HMO plan's rules. In this case, the provider will bill you directly. You then need to submit a claim form to be reimbursed. You will be reimbursed for part of the bill.

To file a claim, follow the instructions on the claim form. If you received an Explanation of Benefits (EOB) statement from another health care company, be sure to include a copy with your claim form.

What happens if I need specialty care that is not available from my HMO?

You may be referred to a non-HMO provider if you need specialized care that your HMO determines to be medically necessary and the care is not available through the HMO in your area. As long as you use the provider you're referred to by your HMO and follow your HMO's rules, you'll be covered for that care.

What happens in an emergency?

In a true emergency, get the care you need as quickly as you can. Assuming you are able, try to contact your HMO, even in an emergency. However, if you are unable to contact your HMO, proceed with the care you need. If you need to seek care from a non-HMO provider, your plan will cover emergency care as long as you follow the plan rules.

What happens if I need care while I'm traveling?

If it's not an emergency and you need care while traveling, call your HMO and your HMO can help you arrange a referral.

Do I pay a deductible?

Neither HMO option has a deductible.

What is a copayment ?

A copayment is a fixed amount you pay at the time you receive services.

What is preauthorization?

Preauthorization is the process by which an HMO reviews the proposed treatment and tells you and your doctor how benefits may be paid. Generally, preauthorized care is paid at the highest level of coverage.

You must obtain preauthorization for certain covered expenses such as a hospital stay. If you don't get the required preauthorization, your cost will be higher because the benefits payable by the plan will be reduced or the expenses will not be covered at all.

What are covered services?

Covered services are services covered by the plan. No medical plan covers everything. If you obtain services that are not covered services, you pay the full cost for those services.

What are the copays I am responsible for?

You are responsible for copays for Office and Emergency Room visits.